DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

August 16, 2010

COF

Max Long, Administrator
Walter Knox Memorial Hospital
1201 East Locust Street
Emmett, ID 83617

CCN: 13-1318 **Re: Complaint Control #: 4586 (EMTALA)**

Dear Mr. Long:

On August 6, 2010, an EMTALA revisit survey was conducted at your hospital, by the Idaho Bureau of Facility Standards (State survey agency) based on an allegation of compliance with the requirements of 42 Code of Federal Regulations (CFR) § 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR § 489.20.

After a careful review of the findings, we have determined that your hospital is now in compliance with these requirements. The proposed termination action from our April 26, 2010, letter is rescinded. We are closing the termination action and this case.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have questions regarding this letter, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

cc: Idaho Bureau of Facility Standards

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

April 26, 2010

Max Long, Administrator
Walter Knox Memorial Hospital
1201 East Locust Street
Emmett, ID 83617

CMS Certification Number: 13-1318

Re: Complaint Control # 4586 (EMTALA)

Dear Mr. Long:

To participate in the Medicare program, a critical access hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861 (e) of the Act. Further, §1866 (b) of the Act authorizes the Secretary to terminate the provider agreement of a critical access hospital that fails to meet these provisions.

Your critical access hospital was surveyed March 30-31, 2010, by the Idaho Bureau of Facility Standards (State Agency) based on an allegation of noncompliance with the requirements of 42 Code of Federal Regulations (CFR) § 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR § 489.20. After a careful review of the findings, we have determined that your critical access hospital violated:

- **The requirements of 42 CFR § 489.24(a) based on failure to provide an appropriate medical screening exam;**

The deficiencies identified are listed on the enclosed form CMS-2567, Summary Statement of Deficiencies.

The purpose of this letter is to notify you of these violations and advise you that under 42 CFR § 489.53, a critical access hospital that violates the provisions of 42 CFR § 489.20 and/or 42 CFR § 489.24 is subject to termination of its provider agreement. Consequently, it is our intention to terminate Walter Knox Memorial Hospital's participation in the Medicare program. The projected date on which the agreement will terminate is **July 25, 2010**.

You will receive a "Notice of Termination" letter no later than July 10, 2010. This final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR § 489.53.

You may avoid termination action and notice to the public either by providing credible allegation or credible evidence of correction of the deficiencies, or by successfully proving that the deficiencies did not exist, prior to the projected public information date. In either case, the information must be furnished to this office so that there is time to verify the corrections. An acceptable plan of correction (POC) must contain the following elements:

- The plan of correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

It is highly recommended that the latest completion date in the plan of correction be no later than **May 26, 2010**. Please submit the POC within 10 days receipt of this letter, to the State survey agency and to the following address:

CMS – Survey, Certification, and Enforcement Branch
Attn: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

A credible allegation of correction by the critical access hospital may require a resurvey to verify the corrections. However, when evidence of correction is provided by the critical access hospital, this office must decide whether the evidence of correction is sufficient to halt the termination action. If the evidence is not sufficient in itself to establish that the hospital is in compliance, a resurvey is required for verification of correction.

If we verify your corrective action, or determine that you successfully refuted the findings contained in this letter by proving that allegations were in error, your termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

Enclosure

cc: Idaho Bureau of Facility Standards
Office of Civil Rights (OCR)

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

May 17, 2010

Diane Wood, Chief Nursing Officer
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

CMS Certification Number: 13-1318

Re: Complaint Control # 4586 (EMTALA)

Dear Ms. Wood:

We are in receipt of Walter Knox Memorial Hospital's plan of correction dated May 5, 2010, and the additional information submitted May 13, 2010. We have determined that Walter Knox Memorial Hospital's allegation of compliance is credible based upon our review of the documentation provided; however we are requesting that the Idaho Bureau of Facility Standards (State Agency) conduct a revisit to ensure full implementation of the corrective actions. The proposed termination action from our April 26, 2010, letter is suspended pending the results of the revisit by the State Agency. We will notify you of our final decision once we have the results of the revisit.

If you have questions regarding this letter, please contact Kate Mitchell of my staff at (206) 615-2432 or Catherine.mitchell@cms.hhs.gov.

Sincerely,

Kate Mitchell

for Steven Chickering
Western Consortium Survey & Certification Officer
Division of Survey & Certification

cc: Idaho Bureau of Facility Standards

WALTER KNOX MEMORIAL HOSPITAL

Walter Knox Memorial Hospital
1202 E Locust Emmett, ID 83617
208-365-3561 Fax: 208-365-3572 (ER)

FAX

To:	~~Idaho Dept of Health + Welfare~~ Atty Patrick Hendrickson or Gary Giles	Fax:	364-1888
From:	Diane Wood	Date:	5/5/10
Re:	Complaint Control # 4586	Pages:	14
Cc:			

☐ Urgent ☒ For review ☐ Please comment ☐ Please reply ☐ Please recycle

Notes:

Here is a copy of the corrective action plan that I have sent to Kate Mitchell at the Survey, Certification + Enforcement Branch of the Department of Health + Human Services

RECEIVED
MAY - 5 2010
FACILITY STANDARDS

Attention: This fax is intended only for the use of the person or office to whom it is addressed and contains privileged or confidential information protected by law. All recipients are hereby notified that inadvertent or unauthorized receipt does not waive such privilege and that unauthorized dissemination, distribution or copying of this communication is prohibited. If you have received this fax in error, please destroy the attached document(s) and notify the sender of the error by calling 208-365-3561.

confidential

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICE

PRINTED: 04/2612010
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	BLDG _____ WING _____	C 03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	EMMETT, ID 83617
1202 EAST LOCUST STREET	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An EMTALA complaint investigation survey was conducted at your CAH on March 30-31, 2010, in response to the self-reported complaint # 4586. Based on interview of CAH staff and EMS personnel, review of medical records, hospital policies, and ambulance run sheets, it was determined the hospital failed to comply with the provisions at CFR 489.24(a). As a result, a patient transported to the ED via ambulance, did not receive an MSE. The surveyors completing the survey were: Patrick Hendrickson, RN, HFS Gary Giles, RN, HFS Acronyms used on this report include: CAH = Critical Access Hospital CNO = Chief Nursing Officer ED = Emergency Department EMS = Emergency Medical Services EMT = Emergency Medical Technician lbs = Pounds LPN = Licensed Practical Nurse MSE = Medical Screening Evaluation	C 000		
			Additional training will be mandatory for all nursing staff who work in the Emergency room & will be completed within the next 30 days. (See attached)	4/7/10
			EMTALA regulations regarding appropriate transfers & the required documentation will be presented at the next Medical Staff meeting for provider education. (See attached)	4/13/10
C2400	The following EMTALA deficiencies were cited as a result of the investigation. 489.20(1) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: The CAH's "Emergency Treatment and Active Labor Act (EMTALA,) Medical Screening	C2400	RECEIVED MAY - 5 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Max Frow | TITLE: CEO | (X6) DATE: 5-5-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PAGE 2/14 * RCVD AT 5/5/2010 12:48:19 PM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/0 * DNIS:1888 * CSID:2083653578 * DURATION (mm-ss):02-42

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C2400	Continued From page 1 Examination" policy, dated 9/01/99, stated all patients who presented to the ED were to receive an appropriate MSE by a physician, RN, or mid-level provider. This policy was not followed as evidenced by the CAH's failure to provide an appropriate MSE to 1 of 22 patients reviewed (Patient #22), who came to the ED seeking emergency medical services. Refer to A2406 as it relates to the failure of the CAH to ensure a MSE was completed for all patients presenting to the ED seeking emergency medical services.	C2400		
C2406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph *(b)* of this section; the hospital must (i) provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as	C2406		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04126/2010
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLEPJCLIA IDENTIFICATION NUMBER:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A B WING [redacted]	C 03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL 1202 EAST LOCUST STREET	EMMETT, ID 83817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C2406	Continued From page 2 defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act. (c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.	C2406	Other EMTALA related topics will be presented at each of the monthly Nursing & Medical Staff meetings over the next year. These presentations will use 'The EMTALA Answer Book 2010 Edition' as a resource. ER nursing staff not present at the meeting will be required to read & initial the material presented. EMTALA educational materials will also be provided by Attorney Kim Stanger of Hawley Troxell & will be included in the information that each nursing staff member is required to read & initial. EMTALA information will be included in the orientation materials received by each new Nursing staff who may be required to assist with providing care in the Emergency Room.	4/1/11 4/1/11 6/1/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2010
FORM APPROVED
DMB NO. 0938-039 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	B. WING	C 0313112010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL L O C U S T S T R E E T	1202 EAST EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
C2406	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of medical records and CAH policies, and CAH staff and EMS personnel interviews, it was determined the CAH failed to provide an appropriate medical screening examination to 1 of 22 patients reviewed (Patient #22) who came to the ED seeking emergency medical care. This resulted in the inability of the CAH to rule out emergency medical conditions before a patient was taken to a secondary hospital. Findings include: 1. An Ambulance Run Sheet, dated 3/24/10 at 9:36 PM, was reviewed. The Run Sheet included the following information: Patient #22 complained of hip pain and needed the services of the EMS. The ambulance arrived at Patient #22's residence at 9:46 PM. Patient #22 was assisted out of his bed and was able to walk a short distance to the front door of his residence. At that point, he stated he could not proceed any further. Patient #22 was then placed on a back board and transferred to the CAH via ambulance. At 10:05 PM, the EMS personnel called the CAH and gave a report of Patient #22's condition and weight. At 10:07 PM, the ED LPN called back to the ambulance personnel advised them they could not care for Patient #22. The reason given was that the CAH did not have the equipment capable to take the needed X-rays of his hip. The CAH wanted the ambulance to divert to another hospital at this point However, by the time the call came in, the ambulance had arrived at the CAH's ED. The EMS personnel then called their supervisor and advised him of the situation. Patient #22 remained in the ambulance. The EMS personnel went into the ED and talked to the	C2406	To ensure compliance with the EMTALA regulations, Quality Indicators will be added & assessed during the audit of the ER charts & reported quarterly starting February. (See Attached QI form)	5/1/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	C 03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	EMMETT, ID 83617
1202 EAST LOCUST STREET	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C2406	I Continued From page 4 physician and the ED LPN. The Ambulance Run Sheet stated the EMS personnel left the ED and took Patient #22 to another hospital. No one from the CAH's ED staff saw Patient #22 and at 10:50 PM, they arrived at the secondary hospital. On 3/30/10 at 3:05 PM, the EMT involved in the above transport was interviewed. She confirmed the above events to be true and factual. 2. CAH personnel interviews were conducted. On 3130/10 starting at 1:30 PM, the ED physician who was on duty when Patient #22 presented to the ED, was interviewed. She stated she was told by the LPN working in the ED that an ambulance was en route to the hospital with a patient who was complaining of lower back and hip pain. She stated she was further told by the LPN that Patient #22's vital signs were reported as normal. However, she said she was told by the LPN that the patient weighed approximately 500 lbs. She stated she was concerned because the CAH did not have the capability to perform radiologic diagnostic tests on Patient #22 due to his size. She stated she had the LPN call the Radiology Technician to see if the CAH could perform radiologic diagnostic tests on a patient that large. The ED physician stated the LPN called the Radiology Technician who confirmed the CAH was unable to perform radiologic diagnostic tests on Patient #22 due to his weight. The ED physician further stated she directed the LPN to call the ambulance to divert the patient to another hospital but was told the ambulance had already arrived at the ED. The ED physician stated the LPN, with her permission, told ambulance personnel to take Patient #22 to a different hospital that was capable of performing	C2406	Topics will be presented & audits will be performed by Diane Wood, CNO and others as available, with minutes & attendance recorded for each meeting. Activities will continue throughout the year with completion by April 1, 2011. The CNO, Diane Wood, will be responsible for ensuring that the education and QI audits are completed.	4/1/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	03/31/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

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C2406	Continued From page 5	C2406		

radiologic diagnostic tests. She stated she did not see Patient #22 and said she did not perform an MSE. The above statement was confirmed in a written statement by the ED Physician that was not dated or timed.

The LPN who worked in the ED the evening of 3/24/10, confirmed the ED physician's statements in a written document, dated 3/24/10, which was not timed. He also confirmed the ED physician's statements during an interview on 3/31/10 at 9:10 AM. The LPN stated the ED physician did not conduct an MSE.

During an interview with the CNO on 3/30/10 at 1:30 PM, she stated a medical record had not been established for Patient #22. She stated he had come to the hospital but he had remained in the ambulance at the entrance to the ED before being transported to another hospital.

Patient #22 did not receive a medical screening examination.

Minutes for Nursing Staff Meeting held April 7, 2010

Meeting began at 6 pm with a discussion of the situation that presented itself in the ER and resulted in an EMTALA violation. It was discussed from the viewpoint of the ER staff member, ER physician, Patient & EMT. What actually occurred and what should have occurred were compared with an emphasis on the missing MSE, transfer paperwork and call to the receiving facility. The section 'Transfer and Receiving: Requirements and Risks' of the Emergency Medical Treatment and Labor Act was then read and questions answered. (See attached) The proposed plan of correction was reviewed.

Update on revenues was given with graph illustrations showing the average daily revenue compared to the break even level. March was able to end just above the breakeven line, but April doesn't look very good so far. Hopefully it will improve, but we all need to watch expenses.

Speaking of expenses, March showed an increase in the number of un-scanned items in both the ER & M/S POI systems. January showed really low numbers in the missed items, so we know you can do it.

Survey comments from the QI report were reviewed, both positive & negative comments. Staff was reminded to keep patient rooms clean of litter & not put Kleenex or bloody tissues on the food trays. Staff were reminded to think about how they are perceived by those who they are interacting with. People, whether they are the patient or a family member, are under stress when coming to the hospital & are not going to be in the same frame of mind as when you see them elsewhere. Just because we are so comfortable in this setting doesn't mean that everyone else is the same. There were also discussions concerning a couple of the PI reports that impacted nursing. ER staff were reminded that new patients need to have an MSE within 30 minutes & not to tell the registration clerk that they are too busy. Also discussed including patient instructions to remove Coban approx 30 minutes after it has been applied to discharge instructions.

All items that enter the Shred box will stay in the shred box. The shred boxes will no longer be opened by maintenance regardless of what has been discarded. Be forewarned, be cautious.

The nursing department now has its own internal E-mail address if you want to send something to everyone in the department via Zimbra.

HMS - Doug will take responsibility for placing calls to HMS regarding problems that you are having with the system if you will provide details of what you did in each screen & what the issue is. The next implementation will be E-forms this fall.

There was a suggestions made to add the No Tobacco policy to the Conditions of Admission form. Diane will follow-up with Sue & Max.

Health Fair will be held on May 15. See Sue to volunteer.

Employee Banquet will be at La Costa on May 12. There will be 6 entrees & Sue is taking suggestions. If there is something that you really like at La Costa, let Sue know so that it can be included in the buffet choices.
We have the EZ IO (Intraosseous) system now & it will be kept in the ER, in the bottom drawer of the Crash cart. We also have the Glide Scope that Alan has started orienting the doctors to use that is kept in Surgery.
HIPPA was discussed in regard to the increases in the amount that can be charged for fines and techniques to use when doing an MSE in the Waiting room to keep personal health information as confidential as possible.
Staff were again reminded to be sure to thoroughly clean the area and gurneys in the Same Day Surgery area when they are used for ER overflow of patients.

Brownies were enjoyed by all of those present with lots of extras for night shift & to take-home.

Adjourned 19:20

The statute requires hospitals that participate in the Medicare and Medicaid programs and that have a "dedicated emergency department" to provide an appropriate "medical screening examination" to determine whether an individual who comes to the ED has an "emergency medical condition." The regulation defines a dedicated ED as any department or facility of a hospital that (1) is licensed by the state as an ED, (2) is held out to the public as providing treatment for emergency medical conditions, or (3) actually provided treatment for emergency medical conditions on an urgent basis for one-third of the visits to the department in the preceding calendar year. The preamble to the 2003 final rule notes that hospital labor and delivery departments and psychiatric units—where patients could present for emergency treatment—could meet the definition of dedicated EDs and, thus, would need to adhere to EMTALA's requirements (CMS "Medicare Program" 2003).

Hospitals must provide a medical screening exam that is within the capability of the hospital's ED, including services routinely available in the ED, to determine whether an emergency medical condition, as defined by EMTALA, exists (42 USC § 1395dd). CMS interpretive guidance in the "State Operations Manual" describes the medical screening exam as "the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC [emergency medical condition] or not." An appropriate medical screening exam is one that is rendered in a nondiscriminatory manner. CMS interpretive guidance indicates that medical screening exams are to be performed by staff who are designated as qualified by hospital bylaws, rules, or regulations and meet the requirements that are set forth elsewhere in the regulations at 42 CFR § 482.55. (CMS "Interpretive Guidelines")

EMTALA is triggered regardless of whether the individual who comes to the ED is indigent or insured. EMTALA prohibits hospitals from delaying individuals' access to emergency assessment, stabilization, or transfer because of their insurance status. Once an emergency medical condition is determined to exist, hospitals must either stabilize the patient or, if unable to stabilize the patient, make an appropriate transfer (with patient consent when possible) to a hospital with the capability of stabilizing the patient if the benefits of transfer outweigh the risks. After stabilization, patients may be discharged, admitted, or transferred.

In an attempt to reconcile conflicting judicial opinions about whether EMTALA obligations apply to admitted patients, CMS revised its 2003 regulations to state that EMTALA obligations do not apply once a patient is admitted to a hospital provided that the admission is not made as a subterfuge to avoid EMTALA obligations. Instead, hospitals' obligations for admitted patients are outlined in the Medicare Conditions of Participation. Nevertheless, courts continue to deviate from the agency's stance. Refer to the discussion Admitted Patients: Ensuring That EMTALA Obligations End for more information.

In 2008, CMS proposed a narrow application of EMTALA to patients who remain unstabilized after admission and require transfer to resolve the condition. CMS proposed that EMTALA obligations apply to the receiving hospital, including specialty hospitals. CMS withdrew the proposal after numerous commenters noted that the proposal ran counter to the policy in CMS's 2003 regulations stating that EMTALA obligations end once the patient is admitted. (CMS "Medicare Program" 2008).

Transfer and Receiving: Requirements and Risks

EMTALA regulates the transfer of patients from the hospital ED. Transfer occurs when a patient is moved outside the hospital's facilities at the direction of any person employed by or affiliated or associated, directly or indirectly, with the hospital. Individuals who have been declared dead or who leave the facility without the facility's permission are not considered to have been transferred (42 CFR § 489.24).

Unstable individuals, as defined by the regulation, may not be transferred unless one of the following options is used (CMS "Interpretive Guidelines"):

Written request. The individual or a legally responsible person acting on the individual's behalf requests the transfer after being informed of the hospital's EMTALA obligations and the risks and benefits of transfer. The request must be in writing; it must indicate the reasons for the request for transfer and the individual's awareness of the risks and benefits of transfer and be signed by the individual or the individual's representative. The request must be made a part of the patient's medical record, and a copy must be sent to the receiving facility with the individual.

Physician certification. A physician signs a certification indicating that based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of the appropriate medical care at another medical facility outweigh the increased risks to the individual (or, in the case of a woman in labor, to the woman and the fetus) from being transferred. The certification must contain a summary of the risks and benefits that the physician considered in ordering the transfer.

Qualified medical person certification. Under certain circumstances—for example, a physician is not physically present in the ED at the time of transfer—a qualified medical person may sign the certification after a physician, in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits on which it is based. The physician's countersignature must be obtained within an established time frame according to hospital policy and procedures. Hospital bylaws, rules, or regulations must designate criteria for granting medical staff privileges to qualified medical personnel.

A transfer is appropriate when it fulfills all four of the following requirements:

1. The transferring hospital must provide medical treatment within its capacity that minimizes the risks to the health of the individual and, in the case of a woman in labor, the health of the fetus.
2. The receiving hospital must have available space and qualified personnel for the treatment of the individual to be transferred and must agree to accept the transfer and provide appropriate medical treatment.
3. The transfer must be made by qualified personnel; employ appropriate transportation equipment, as required; and include the use of necessary and medically appropriate life-support measures during the transfer.
4. The transferring hospital must send the receiving hospital all medical records relating to the emergency condition available at the time of the transfer, including the following:
   - Available history
   - Records related to the individual's emergency medical condition
   - Observations of signs and symptoms
   - Preliminary diagnosis
   - Results of diagnostic studies or telephone reports of the studies
   - Records of treatment provided
   - Results of any tests
   - Written informed consent or certification or copies of either document
   - Name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment
   - Other records (test results or other records not yet available), as soon as practical after transfer

Hospitals that are capable of stabilizing the individuals involved must accept appropriate patient transfers. Hospitals can be held liable for the actions of their physicians regarding transfers. A federal appeals court in 2002, for example, held a hospital liable under EMTALA for the actions of a physician who refused to accept the transfer of a trauma patient (*St. Anthony Hospital v. U.S. Department of Health and Human Services*). The hospital's emergency physician declined to accept the transfer, deferring to the judgment of the on-call thoracic and vascular surgeon that the patient, who had already been refused transfer to a university hospital unable to receive the patient, remained the university hospital's "problem."

Because hospitals are bound by the decisions of their duly authorized agents, the *Healthcare Risk Control (HRC) System* recommends that hospitals be cautious in designating who is authorized to act as an agent of the hospital to accept or decline patient transfers. In the opinion of some experts, hospitals face an increased risk of exposure to EMTALA citations and liability actions by permitting on-call physicians to accept or reject transfers (Bitterman). On-call physicians may not have accurate information about the current capabilities of the hospital at the time of the transfer request and may have perspectives and interests that differ from the hospital's obligations under EMTALA.

Several factors support designating the on-duty emergency physician as responsible for accepting or declining patient transfers. Generally, emergency physicians are more knowledgeable about hospitals' EMTALA obligations than physicians in other specialties. The on-duty emergency physician is typically able to efficiently manage a transfer request in a timely manner by speaking to the transferring physician or evaluating the patient and, with knowledge of the hospital's capabilities, ascertaining and coordinating the specialty care services and resources that the patient would require. Hospitals should also document in writing which members of the medical staff have been authorized to accept or decline transfers.

For some hospitals—those without neonatal intensive care units, for example—one way to minimize the risk of noncompliance concerning transfers is to enter into transfer agreements with hospitals with special capabilities, such as facilities capable of managing high-risk deliveries or caring for high-risk infants.

CMS has taken the position that specialty hospitals such as heart and orthopedic hospitals that do not have a dedicated ED must accept, within the capacity of the hospital, an appropriate transfer from a requesting hospital, and the agency has taken enforcement action against specialty facilities for failing to accept appropriate transfers when the facilities had the capacity to treat the transferred individuals. This CMS policy was clarified in a 2006 final rule, published in the *Federal Register* on August 18, 2006, as a part of the agency's regular update to the Medicare program's hospital Inpatient Prospective Payment System (CMS "Medicare Program" 2006). CMS refers to these facilities as "hospitals with specialized capabilities." The agency's policy for specialty hospitals is also reflected in its 2009 interpretive guidelines.

The transfer of unstable patients is a high-risk endeavor. Should an adverse event occur during transfer—or as a result of transfer or inappropriate transfer—the hospital and individuals involved may be at risk for regulatory sanctions as well as for liability exposure for medical negligence. Hospitals should encourage the adoption and use of standard transfer forms for the transfer of unstable patients and patients requesting transfers. A discussion of the risks that are inherent in the transfer of patients with psychiatric conditions appears in Transfer Risks for Patients with Psychiatric Conditions.

Plan of Correction for technical EMTALA violation. (Self reported)
Tag A 2406 Failure to perform Medical Screening Examination

Walter Knox Memorial Hospital will continue to provide additional education to Emergency room staff & providers regarding EMTALA regulations.

- Additional training will be mandatory for all Emergency room nursing staff and will be completed within the next 30 days.
- EMTALA regulations regarding appropriate transfers & required documentation will be presented at the next Medical Staff meeting scheduled for April 13.
- Other EMTALA related topics will be presented at each of the monthly Nursing & Medical Staff meetings over the next year. These presentations will use 'The EMTALA Answer Book 2010 Edition' as a resource. ER nursing staff not attending the meetings will be required to read & initial the material presented.
- EMTALA educational materials will also be provided by Attorney Kim Stanger of Hawley Troxell and will be included in the information that each nursing staff member is required to read and initial.
- Topics will be presented by Diane Wood, CNO and others as available with minutes and sign-in sheets for each meeting.
- EMTALA information will be included in the orientation materials received by each of the new Nursing staff who may be required to assist with providing care in the Emergency room.

alter Knox Memorial Hospital Quality Improvement Trending Sheet

Department: Nursing Services

Manager: Diane Wood, CNO

Indicators	Trending/ Benchmark		Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-10
ER patient receives MSE within 30 minutes of arrival		Numerator												
		Denominator												
		% correct	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Care provided by Non-RN staff has been appropiately supervised.		Numerator												
		Denominator												
		% correct	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		Numerator												
		Denominator												
		% correct	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		Numerator												
		Denominator												
		% correct	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

OTES:

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